SENATE BILL No. 465

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

Synopsis: Medicaid reimbursement rates. Requires the office of Medicaid policy and planning to base the rate of reimbursement to providers in Medicaid managed care programs, fee for service programs, and demonstration projects on Medicare rates. Provides guidelines for calculating reimbursement to providers of anesthesia services. Requires the office of Medicaid policy and planning to update reimbursement rates at least once every two years.

Effective: July 1, 2001.

Miller

January 18, 2001, read first time and referred to Committee on Finance.

Introduced

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

SENATE BILL No. 465

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-12-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001] : Sec. 12. **(a)** For a managed care program or demonstration project established or authorized by the office, or established or authorized by another entity or agency working in conjunction with or under agreement with the office, the office must provide for payment to providers in the managed care program that the office finds is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers in order to:

(1) provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards; and

(2) ensure that individuals eligible for medical assistance under the managed care program or demonstration project have reasonable access (taking into account geographic location and reasonable travel time) to the services provided by the managed care program.

(b) In addition to the requirements under subsection (a), the

office shall establish payments to providers for services (as listed in IC 12-15-5-1) under a managed care program or demonstration project established or authorized by the office, or established or authorized by another entity or agency working in conjunction with or under agreement with the office, as follows:

(1) Not less than the most current Medicare relative value unit, as established by the federal Health Care Financing Administration, factoring in the existing geographic practice cost indices and the conversion factor established by 405 IAC 1-11.5-2.

(2) The equivalent of one hundred percent (100%) of the most current Medicare allowable rates if Medicare relative value units are not applicable.

(3) For anesthesia services, the office shall use the following:

(A) The most current American Society of Anesthesiology relative value guide's base, time, and modifier units.

(B) A conversion factor equal to or greater than the most current Medicare conversion factor.

(c) The office shall update payment rates at least one (1) time every two (2) years in compliance with this section.

SECTION 2. IC 12-15-13-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 2. (a) Except as provided in IC 12-15-14 and IC 12-15-15, payments to Medicaid providers must be:

(1) consistent with efficiency, economy, and quality of care; and

(2) sufficient to enlist enough providers so that care and services are available under Medicaid, at least to the extent that such care and services are available to the general population in the geographic area.

(b) If federal law or regulations specify reimbursement criteria, payment shall be made in compliance with those criteria.

(c) In addition to the requirements under subsection (a), the office shall establish payments to providers for services (as listed in IC 12-15-5-1) under a fee for service program or the Medicaid primary care case management program as follows:

(1) Not less than the most current Medicare relative value unit, as established by the federal Health Care Financing Administration, factoring in the existing geographic practice cost indices and the conversion factor established by 405 IAC 1-11.5-2.

(2) The equivalent of one hundred percent (100%) of the most current Medicare allowable rates if Medicare relative value

units are not applicable.

(3) For anesthesia services, the office shall use the following:

(A) The most current American Society of Anesthesiology relative value guide's base, time, and modifier units.

(B) A conversion factor equal to or greater than the most current Medicare conversion factor.

(d) The office shall update payment rates at least one (1) time every two (2) years in compliance with this section.